



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PAIN AND RECOVERY CLINIC OF N HOUSTON
6660 AIRLINE DRIVE
HOUSTON TX 77076

Respondent Name

AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-1455-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary dated January 5, 2011: "Our facility obtained pre-authorization for these services."

Requestor's Supplemental Position Summary dated April 1, 2011: "Our facility had faxed a withdrawal letter for all DOS except for 5/17/10 back on 1/31/11; due to the carrier had reimbursed these services. The ONLY DOS outstanding on this file is 5/17/10."

Amount in Dispute: \$700.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Paid on 1/25/2010 CK #0083461325"

Response Submitted by: Julie Barrera, 16414 San Pedro, Ste. 950, San Antonio, TX 78232

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 17, 2010	Chronic Pain Management – CPT code 97799-CP (7 hours)	\$700.00/day	\$00.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204. Medical Fee Guideline for Workers' Compensation Specific Services. *March 1, 2008, 33 TexReg 626*, sets the reimbursement guidelines for the disputed service.

3. 28 Texas Administrative Code §134.600, requires preauthorization for specific treatments and services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits July 2, 2010

- 19 (197) precertification/authorization/notification absent.

Issues

1. Did the requestor support disputed treatment was preauthorized?
2. Is the requestor entitled to reimbursement?

Findings

1. The respondent denied reimbursement for the disputed services based upon reason code "19 (197) precertification/authorization/notification absent."

The requestor asserts that "Our facility obtained pre-authorization for these services."

On April 29, 2010 the requestor obtained preauthorization approval for 10 sessions of Chronic Pain Management Program between April 21, 2010 and June 8, 2010.

Therefore, the requestor has supported position that the disputed chronic pain management rendered on May 17, 2010 was preauthorized in accordance with 28 Texas Administrative Code §134.600.

2. 28 Texas Administrative Code §134.204(h)(1)(B) states "If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

28 Texas Administrative Code §134.204(h)(5)(A) and (B) states "The following shall be applied for billing and reimbursement of Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs

(A) Program shall be billed and reimbursed using CPT Code 97799 with modifier "CP" for each hour. The number of hours shall be indicated in the units column on the bill. CARF accredited Programs shall add "CA" as a second modifier.

(B) Reimbursement shall be \$125 per hour. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes."

Therefore, the MAR for a non-CARF Chronic Pain Management Program is \$100.00 per hour. Based upon the Table of Disputed Services the requestor listed six (6) dates of service from May 10, 2010 through May 17, 2010. The requestor billed for seven (7) hours per date, for a total of 42 hours. Using the above formula the requestor was due \$4200.00 for dates of service May 10, 2010 through May 17, 2010.

The respondent's payment screen indicates that a check for \$4200.00 was issued on January 25, 2011 for dates of service May 10, 2010 through May 17, 2010. The check number was 0083461325. The Division finds that the requestor has been paid for date of service May 17, 2010 in accordance with 28 Texas Administrative Code §134.204(h)(5)(A) and (B). Therefore, additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

4/13/2012
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.